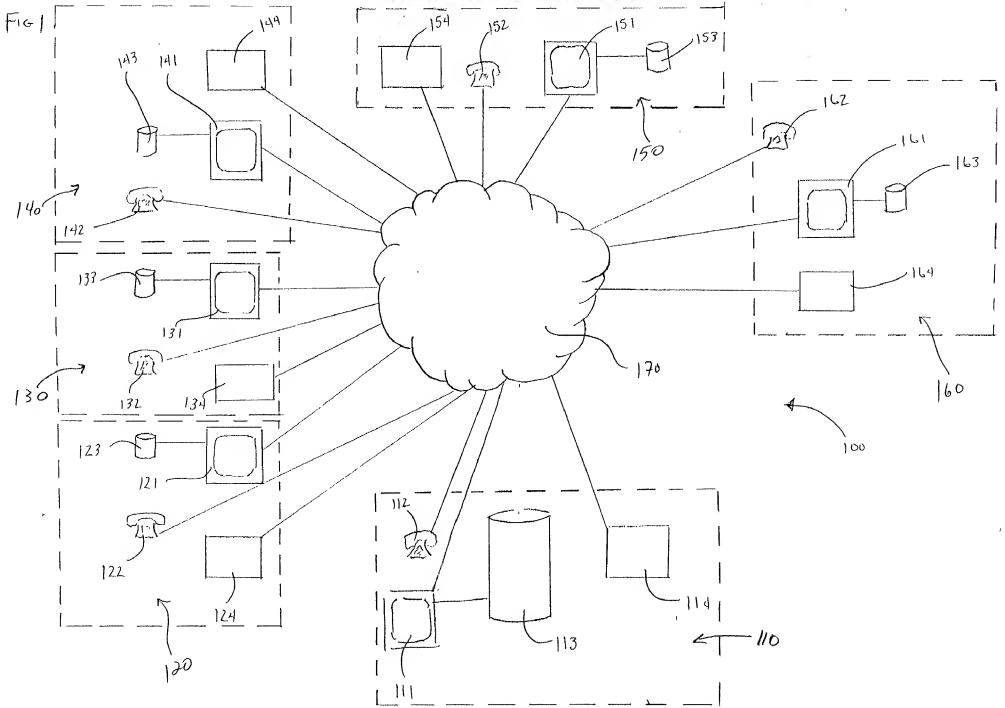
Fig 1
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Fig. 2

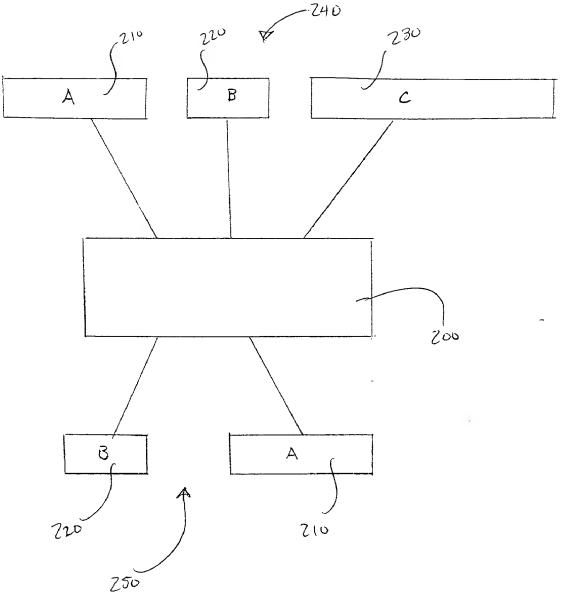


Fig. 3

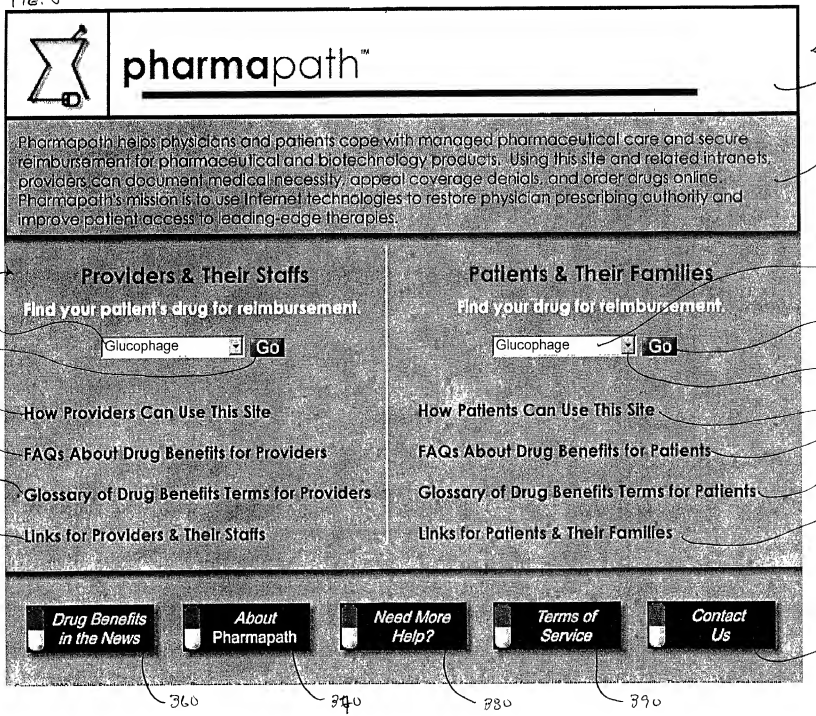


FIG. 4A

400

Need More Help?

Please let us know what type of Pharmapath user you are, so we can better assist you.

In the form below, we are not seeking any personally identifying information. Your e-mail address and other information will be kept strictly confidential, and will not be shared with any third party.

Describe yourself

○ Physician office staff member ○ Physician ○ Non-physician caregiver ○ Patient
○ Member of a patient's family ○ Other

For Providers and Their Staffs

Describe your practice

- ○ Multi-specialty private practice
- ○ Single specialty care private practice
- ○ Primary care private practice
- ○ Non-hospital clinic
- ○ Hospital-affiliated clinic

If you are a physician, what is your specialty?
Please Select

If you are on the administrative staff of a practice or clinic: Please Select

For Patients and Their Families

What type of insurance do you have?
(more than one may apply)

- ☐ HMO Plan
- ☐ PPO Plan
- ☐ Point of Service or "POS" plan
- ☐ Blue Cross or Blue Shield plan
- ☐ Other traditional insurance plan
- ☐ Medicare
- ☐ Medicaid
- ☐ No insurance
- ☐ Other insurance
- ☐ Not sure

Fig 48

Send us an e-mail with your questions or comments, and we will respond as soon as we can.

E-mail Address

Submit Clear

Thanks for your interest in Pharmapath.

Comments

410

Fig. 5A

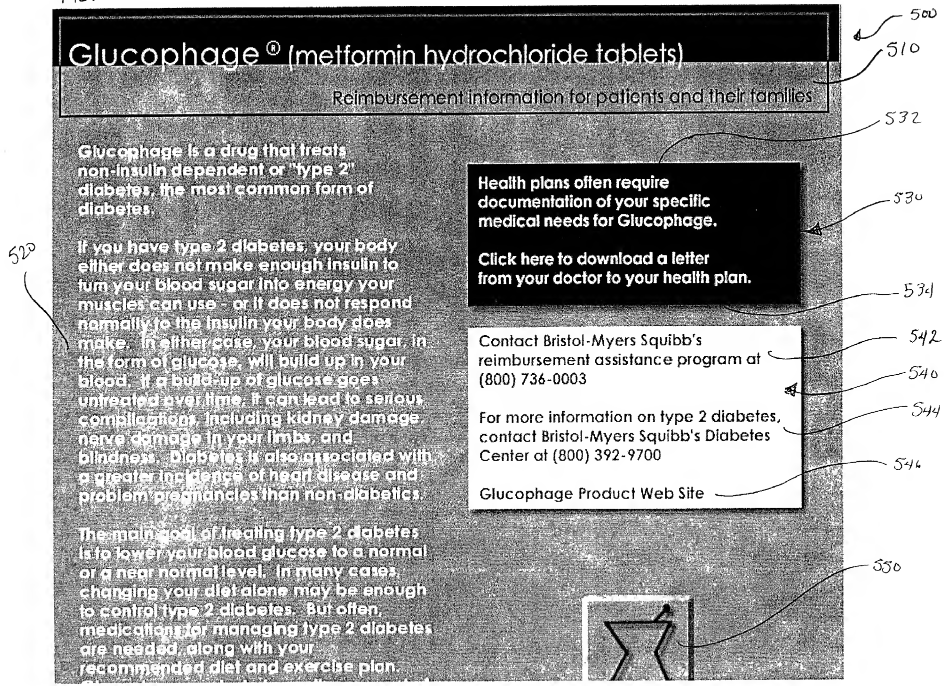

500
510
Glucophage® (metformin hydrochloride tablets)
Reimbursement information for patients and their families
520
Glucophage is a drug that treats non-insulin dependent or "type 2" diabetes, the most common form of diabetes.
If you have type 2 diabetes, your body either does not make enough insulin to turn your blood sugar into energy your muscles can use - or it does not respond normally to the insulin your body does make. In either case, your blood sugar, in the form of glucose, will build up in your blood. If a build-up of glucose goes untreated over time, it can lead to serious complications, including kidney damage, nerve damage in your limbs, and blindness. Diabetes is also associated with a greater incidence of heart disease and problem pregnancies than non-diabetics.
The main goal of treating type 2 diabetes is to lower your blood glucose to a normal or a near normal level. In many cases, changing your diet alone may be enough to control type 2 diabetes. But often, medications for managing type 2 diabetes are needed, along with your recommended diet and exercise plan.
532
530
Health plans often require documentation of your specific medical needs for Glucophage.
Click here to download a letter from your doctor to your health plan.
534
542
540
544
546
Contact Bristol-Myers Squibb's reimbursement assistance program at (800) 736-0003
For more information on type 2 diabetes, contact Bristol-Myers Squibb's Diabetes Center at (800) 392-9700
Glucophage Product Web Site
550

Fig. 5B

Fig. 5B

500

Glucophage works to lower the amount of glucose in your blood by helping your body respond better to the insulin your body is already producing, decreases sugar production in the liver and decreases intestinal absorption of sugar, instead of producing more insulin. Glucophage rarely causes hypoglycemia, when used alone and as prescribed, or low blood sugar, and it usually does not cause weight gain.

522

Important Information

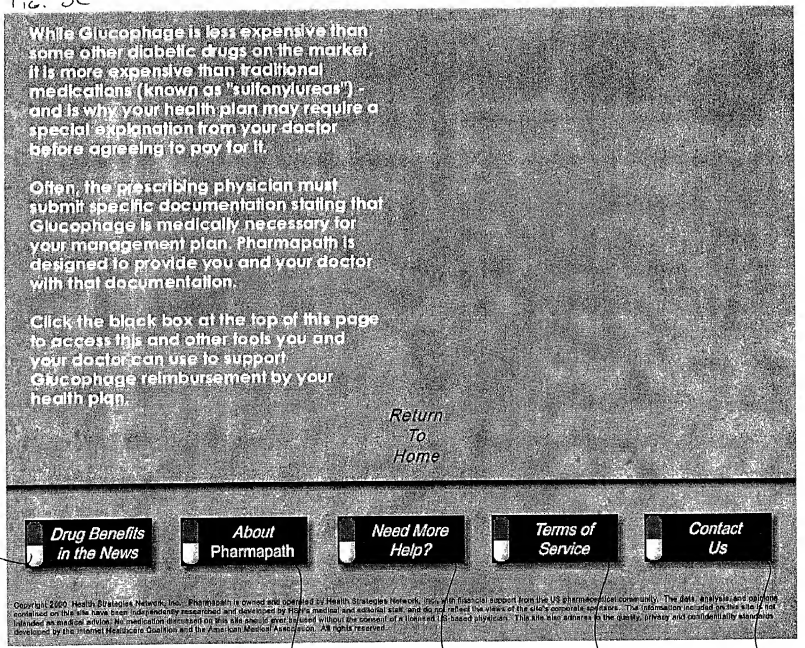
The most serious side effect associated with Glucophage (metformin hydrochloride tablets) is called lactic acidosis, which is rare and has occurred in one in 33,000 patients on Glucophage over the course of one year. If lactic acidosis occurs, it can be fatal in up to half the cases. You should not take Glucophage if you have kidney disease or dysfunction, if you are 80 or older (unless you have first had your kidneys tested), if you are taking medication for congestive heart failure, if you have a history of liver disease, or if you drink alcohol excessively. The most common side effects are minor ones such as diarrhea, nausea, and upset stomach, which usually occur during the first few weeks on Glucophage.

524

Reimbursement Issues

Questions or problems regarding this information?
Click here to contact us.

Fig. 5C



500

360

370

380

390

350

Fig 6A

600

- HOME
- HISTORY OF GLUCOPHAGE®
- FOR MORE INFORMATION
- PRESCRIBING INFORMATION
- RELATED LINKS

For more information on type 2 diabetes call 1 - 800 - 392 - 9700

Welcome to GLUCOPHAGE.com!

Bristol-Myers Squibb, the makers of GLUCOPHAGE® (Metformin Hydrochloride Tablets), is committed to providing helpful information for people with type 2 diabetes, those who care for them, and those who are interested in learning more about diabetes. Our goal is to provide you with information you can start using today.

Did you know that there is something better than GLUCOPHAGE®? Visit GLUCOVANCE.com to learn more about this exciting new treatment option!

SIGN UP FOR INFORMATION ON TYPE 2 DIABETES

If you would like to be notified about information regarding the management of type 2 diabetes, please enter your e-mail address and then press "Submit."

E-MAIL ADDRESS: [ ] Submit

See our Privacy Policy to view our commitment and diligence in protecting your privacy.

Fig 6B

600

IMPORTANT SAFETY INFORMATION ABOUT GLUCOPHAGE AND GLUCOVANCE

Glucophage and Glucovance are not for everyone. In rare cases, Glucophage or Glucovance may cause lactic acidosis. If it occurs it can be fatal in up to half of the cases. Lactic acidosis occurs mainly in people whose kidneys are not functioning properly. You should not take these drugs if: you have kidney problems, are 80 or older (unless you have your kidneys tested first), are taking medication for heart failure, are seriously dehydrated, have a severe infection, have a history of liver disease or drink alcohol excessively.

The most common side effects are diarrhea, nausea, and upset stomach. Symptoms of hypoglycemia (low blood sugar), such as lightheadedness, dizziness, shakiness, or hunger may occur.

GLUCOVANCE™ is a trademark of LIPHA s.a. GLUCOPHAGE® is a registered trademark of LIPHA s.a. Licensed to Bristol-Myers Squibb Company.

MEDWATCH, 1-800-332-1088, is available to report any serious adverse events for any drug.

Your use of the information on this site is subject to the terms and conditions of our Legal Policy.

FIG 7.

[DATE] 710

700

[PAYER NAME] 712
[PAYER ADDRESS] 714
[PAYER CITY, STATE, ZIP] 716

Re:
[PATIENT NAME] 718
[DATE OF BIRTH] 720
[PATIENT'S SUBSCRIBER NUMBER] 722
[POLICY ID/GROUP NUMBER] 724

730

Greetings:

In support of reimbursement for Glucophage® (metformin hydrochloride tablets) for [PATIENT NAME], our clinical examination combined with the patient's history indicate that this patient has type 2, (non-insulin dependent) diabetes
(ICD-9-CM code 250.2), and that our first-line approach to managing this condition with diet and exercise is not
sufficient to control the blood sugar in this patient.

Our examination and history further indicate that this patient is an ideal candidate for Glucophage.

PICK THE PARAGRAPH FROM THE FOLLOWING THAT APPLIES...

742 - The patient's blood sugar levels are not adequately controlled with diet and exercise, and requires drug therapy
as part of their management plan.

740

744 -The patient is obese and metformin therapy is usually not associated with weight gain.

750 It is my clinical judgment that treatment with metformin is indicated for this patient. I further believe that a failure
to reimburse for this drug is to deny this patient access to the standard of care to which he/she is contractually entitled
as a member of your health plan.

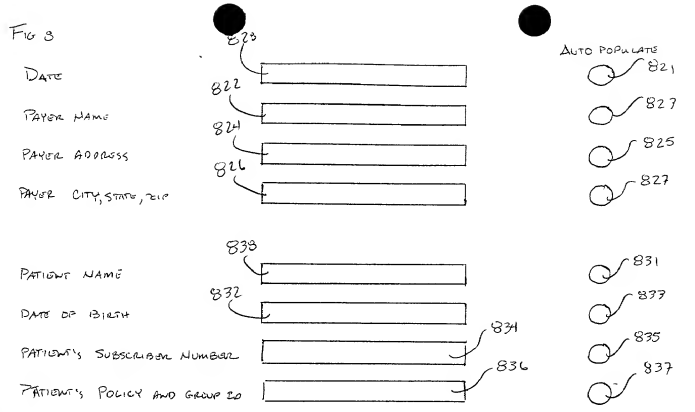
If you require further documentation regarding this matter, please feel free to contact me at my office.

Sincerely,

752

[PRESCRIBING PHYSICIAN]
[PROVIDER NUMBER]

FIG 8



PICK THE PARAGRAPHS FROM THE FOLLOWING WHICH APPLY:

841 INDICIA 1 PARAGRAPH

842 INDICIA 2 PARAGRAPH

840

IF INDICIA 1 WAS SELECTED, PICK THE PARAGRAPHS FROM THE FOLLOWING WHICH APPLY:

851 INDICIA 3 PARAGRAPH

852 INDICIA 4 PARAGRAPH

850

IF INDICIA 2 WAS SELECTED, PICK THE PARAGRAPHS FROM THE FOLLOWING WHICH APPLY:

861 INDICIA 5 PARAGRAPH

862 INDICIA 6 PARAGRAPH

860

880 AUTO POPULATE FROM LOCAL DATA BASE

AUTO POPULATE FROM SYSTEM

810

870 ELECTRONIC SIGNATURE

Fig. 9

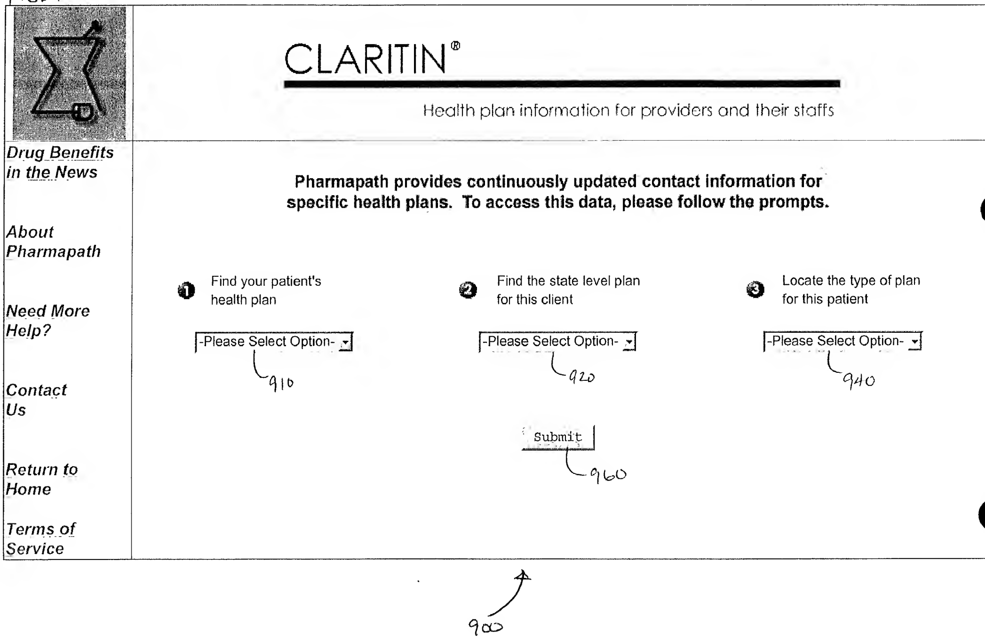
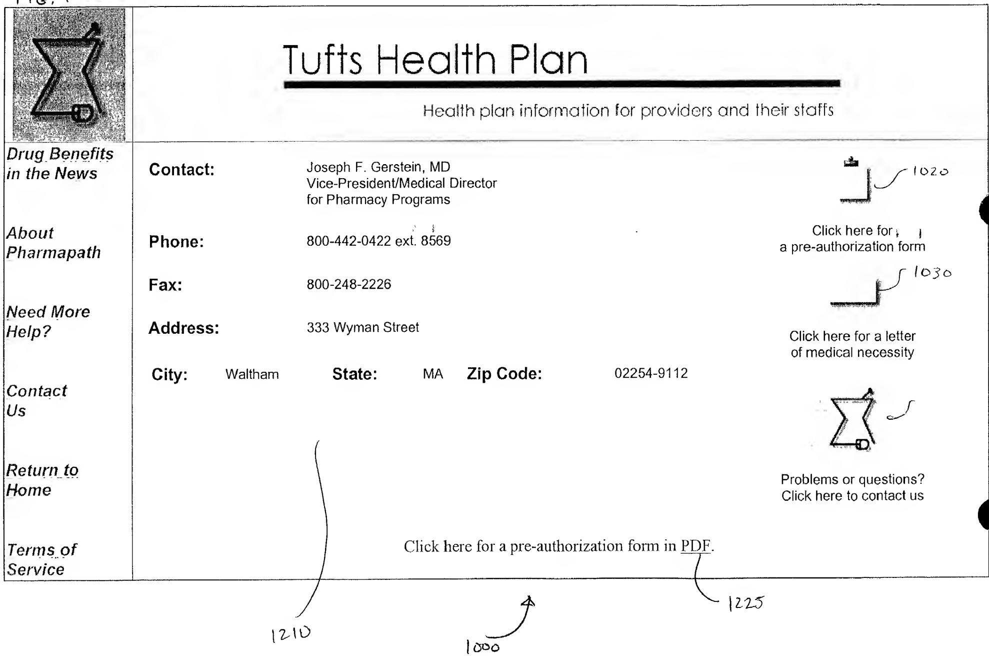

CLARITIN®
Health plan information for providers and their staffs
Drug Benefits in the News
About Pharmapath
Need More Help?
Contact Us
Return to Home
Terms of Service
Pharmapath provides continuously updated contact information for specific health plans. To access this data, please follow the prompts.
1 Find your patient's health plan
-Please Select Option-
910
2 Find the state level plan for this client
-Please Select Option-
920
3 Locate the type of plan for this patient
-Please Select Option-
940
Submit
960
900

FIG. 10


1000
Tufts Health Plan
Health plan information for providers and their staffs
Drug Benefits in the News
About Pharmapath
Need More Help?
Contact Us
Return to Home
Terms of Service
Contact: Joseph F. Gerstein, MD
Vice-President/Medical Director
for Pharmacy Programs
Phone: 800-442-0422 ext. 8569
Fax: 800-248-2226
Address: 333 Wyman Street
City: Waltham State: MA Zip Code: 02254-9112
1020
Click here for a pre-authorization form
1030
Click here for a letter of medical necessity
Problems or questions? Click here to contact us
Click here for a pre-authorization form in PDF.
1225
1210
1000

TUFTS Health Plan

FIG. 11A

SecureHorizons
TUFTS Health Plan for Seniors

UNIVERSAL PHARMACY MEDICAL EXCEPTION REQUEST FORM

1100

This medical exception request form should be used for all drug products which have restrictions, such as drugs in the Pre-Authorization Program, the Dispensing Limitations Program, non-covered drugs under the Prescription Alternative Program and for New-to-Market drug products for which a coverage determination has yet to be made by Tufts Health Plan.

PLEASE PHOTOCOPY THIS FORM FOR FUTURE REQUESTS
PLEASE TYPE OR PRINT LEGIBLY

1110

I. MEMBER INFORMATION: Tufts HP Use Only: Date Rec'd_____

NAME: _____
DOB: _____ Date of Request:_____

1120 Tufts Health Plan/Secure Horizons Member ID# _____ (suffix)

II. PRESCRIBER INFORMATION:

1121 **Prescriber is:** [□PCP] [□Specialist (specify)_____] Other (specify) _____

Prescriber:

1122 Name:_____
Address: _____
1123 Telephone: (___) _____
1124 Fax Number: (___) _____
1125 Office Contact Person to answer
1126 questions:_____

1130

III. PRESCRIBER REQUEST: Request coverage for or increased quantity of:

Name of drug:_____
Strength of drug:_____
Form of drug (e.g. tablet, injectable, nasal spray, topical, etc.):_____
Requested frequency of drug: [□once/day] [□twice/day] [□three times/day] [□four times/day] [□once/week] [□once/month] [□other (specify)_____]

Anticipated length of therapy: _____days _____weeks _____months (Number of days/weeks/months) _____maintenance _____other (specify)

FIG 11B

1100

Pertinent patient primary diagnosis for which this drug is indicated (no codes):

Pertinent co-morbid diagnoses (no codes): 1._____ 2._____

Pertinent drugs member is currently taking:

1. _____ 2. _____ 3. _____

Alternative drugs which failed	PL currently on med? (Y/N)	Reason(s) for failure
1.		1.
2.		2.
3.		3.

In the space provided below, please indicate any other information relevant to this patient that indicates the efficacy of the requested product for the condition in question (i.e. lab data, clinical outcomes, patient symptoms, etc.). Please refer to the guidelines for additional information.

1140

IV. DRUGS WITH ADDITIONAL INFORMATION REQUIRED:

Lamisil (tablets) /Sporanox (capsules) (check all that apply)
***Sporanox is not preferred and will be authorized in special circumstances only.**
Limited to nail surface **YES** **NO** ☐Paronychia ☐Peripheral Vascular Disease
☐Systemic Fungus (specify):_____ ☐Immune Deficiency (specify):_____

Injectable Drugs for Multiple Sclerosis (check applicable box below)
***Enclose letter or consult note from Neurologist* - REQUIRED**
☐Relapsing-Remitting MS ☐Secondary-Progressive MS
☐Primary-Progressive MS ☐Progressive-Relapsing MS

Anti-Obesity Medications
_____Height **(in.)** in stocking feet Weight (lbs.) in exam gown_____BMI

1150

PRESCRIBER SIGNTURE:_____ **DATE:**_____
(REQUIRED)

1160

SEND OR FAX COMPLETED FORM TO: Tufts Health Plan/Policy Department

Fig. 12

1200

amarex

Reimbursement Services

1210 insured patients

1220 uninsured patients

1230 claims assistance

Click here for help with a specific plan

insured patients

For Providers

1241 Click here to complete and submit a request for insurance verification

1242 Click here to request a refill of Amarex

1243 Click here for assistance from Lewin

1244 Click here to order Amarex directly from its manufacturer

1240

For The Lewin Group

1251 Click here after insurance coverage has been verified

1252 Click here to authorize shipment of Amarex for an insured patient

1250

Fig 13A

(300

Amarex Insurance Verification Request

Patient's First Name:
Patient's Last Name:
SS#: - -
Date of Birth: January 1 2000
Address:
City: State: ZIP:
Work Telephone: ( ) -
Home Telephone: ( ) -

Primary Insurance (1):
Does this plan include a prescription drug card benefit? ○ Yes ○ No
First Name of Insured:
Last Name of Insured:
Relationship to Patient: Relative
Insurance Address:
City: ST: ZIP:
Policy Number:
Group Number:
Insurance Phone: ( ) -
Plan Number:

Type : ○ Medicare ○ Medicaid ○ Indemnity
○ PPO ○ HMO ○ Capitated
○ Other, please specify:

Secondary Insurance (2):
Does this plan include a prescription drug card benefit? ○ Yes ○ No
First Name of Insured:
Last Name of Insured:
Relationship to Patient: Relative
Insurance Address:
City: ST: ZIP:

FIG. 13B

1300

Policy Number:
Group Number:
Insurance Phone: ( ) -
Plan Number:
Name of Employer:

Type : Medicare Medicaid Indemnity
PPO HMO Capitated
Other, please specify

Physician's First Name:
Physician's Last Name:
Medicare Provider #:
BC/BS Provider #:
Name of Clinic/Hospital:
Address:
City: State: ZIP:
Telephone: ( ) -
FAX: ( ) -
Name of billing contact:
Telephone (if different): ( ) -

Diagnosis: NSCLC
Dose & Description of Frequency and Duration/Regimen:

Method of Administration: SQ IV infusion Pump Other

Where will patient receive Amarex therapy?: Physician Office Hospital Inpatient Hospital Outpatient
Treatment Start/End Date : January 1 2000

Submit Reset

Fig. 14

1400

Amarex Insurance Verification Confirmation

Provider's E-mail address:

PRN:

Patient's Name :

Pre-Authorization Number:

Contact Person at Health Plan:

Health Plan or Other Organization:

Telephone: ( ) -

Comments:

1410

Submit Reset

1420

FIG. 15

1500

Product Shipment Authorization

PRN#

Refer Questions to (enter reimbursement consultant's name):

Physician Name:

Physician's E-mail Address:

DEA Number:

District Budget:

Patient Name:

Item Number (pick one):

- amarixene 400mg, ea; NDC 0002-8701-01; Drug Company's Item Number ZA8701
  Number of Vials:
- amarixene 800mg, ea; NDC 00002-8702-01; Drug Company's Item Number ZA8702
  Number of Vials:

Scheduled administration Date: mm/dd/yyyy

Shipping Address:

City: State: ZIP:

Shipping Telephone: ( ) -

Submit Reset

1510

Fig 16

1600

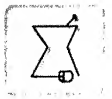
amarex

Reimbursement Services

1210 insured patients

1220 uninsured patients

1230 claims assistance



Click here for help with a specific plan

uninsured patients

For Providers

Click here to apply for the Amarex Patient Assistance Program (1641)

Click here to request a refill of Amarex under the Amarex Patient Assistance Program (1642)

Click here for assistance from the reimbursement consultant (1643)

1640

For The Reimbursement Consultant

Click here after the patient is approved for the Amarex Patient Assistance Program (1651)

Click here when the patient is denied assistance under the Amarex Patient Assistance Program (1652)

Click here to authorize shipment of Amarex under the Amarex Patient Assistance Program (1653)

1650

Fig 17A

170

Patient Assistance Program Application

Welcome to the application process for the company's Patient Assistance Program. The drug company has designed the Patient Assistance Program to help patients receiving outpatient therapy who may not otherwise have access to the drug company's products and who meet the program's criteria.

Please enter the information below as requested and click on the "submit" button. Additional directions will follow. If you have any questions, feel free to call 1-888-4Amarex.

We will review the completed application and notify you of the patient's eligibility within two business days of receipt.

Please click here for full prescribing information.

Patient Information

Patient's First Name:

Patient's Last Name:

Social Security Number: - -

Date of Birth: January 1 2000

Address:

City:

State:

Zip Code:

US Citizen? Yes No

Legal Alien? Yes No

Dosage and Prescribing Information (Complete for one cycle)

Drug Company's Product Name:

Diagnosis: NSCLC

Dosage:

FIG. 17B

1700

Patient Size: m2

mg/Infusion: mg

Number of Weeks in Cycle:

Insurance Information
(check all that apply)

	Has Benefits	Application Pending	Not Eligible	Has Not Applied
Medicaid	○	○	○	○
Other State Medical Assistance	○	○	○	○
Medicare	○	○	○	○
Private Insurance	○	○	○	○
Employer Insurance	○	○	○	○
Federal (FEHB, VA, CHAMPUS)	○	○	○	○
Other:	○	○	○	○

Insurance Company Name:

Address Line 1:

Address Line 2:

City: State: ZIP:

Telephone Number: ( ) -

Policyholder Name:

Patient Relationship to Policyholder: Relative

Policy Number:

Group Number:

Financial Information

List Number in Patient's Household (Applicant & Dependents):

Salary/Wages/Pension: $

Unemployment Compensation: $

Social Security/Supplemental/Disability: $

Other (Alimony, Child Support, etc.) $

Gross Monthly Household Income: $

Non Covered Medical Expenses

(Please list out-of-pocket medical expenses)

Type $
Type $
Type $
Type $
Type $

Total Monthly Non Covered Medical Expenses: $

Provider Information

Physician Name (include professional designation):

State or License or DEA Number:

Clinic or Hospital:

DEA Address:

City: State: ZIP Code:

Application Contact:

Telephone: ( ) -

FIG 17D

Fax: (___) ___-____

1700

Submit | Reset

1710

Fig 18

Patient Assistance Program Acceptance E-mail Message

1800

Provider's E-mail Address:

PRN:

Patient's Name:

Submit Reset

1810

Fig 19

1900

Patient Assistance Program Denial E-mail Message

Provider's email Address:

Patient's Name:

PRN:

Patient not eligible because:

- annual income and/or net worth exceeds the maximum allowable under the program.
- patient outside of US
- (if other, please specify in body of the following message)

Submit Reset

1910

FIG. 20

2000

Product Shipment Authorization

PRN#

Refer Questions to (enter reimbursement consultant's name):

Physician Name:

Physician's E-mail Address:

DEA Number:

District Budget:

Patient Name:

Item Number (pick one):

- amarixene 400mg, ea; NDC 0002-8701-01; Drug Company's Item Number ZA8701
  Number of Vials:
- amarixene 800mg, ea; NDC 00002-8702-01; Drug Company's Item Number ZA8702
  Number of Vials:

Scheduled administration Date: mm/dd/yyyy

Shipping Address:

City: State: ZIP:

Shipping Telephone: ( ) -

Submit Reset

2010

FIG 21

2100

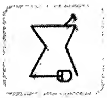
amarex

Reimbursement Services

1210 insured patients

1220 uninsured patients

1230 claims assistance



Click here for help with a specific plan

For Providers

claims assistance

Click here for a bibliography of clinical studies using Amarex 2110

To obtain additional information about Amarex, call 1-800-4AMAREX 2120

Click here for assistance from the reimbursement consultant 2130

Select a letter of medical necessity for: 2140

- Breast Cancer 2141
- Lung Cancer 2142
- Ovarian Cancer 2143
- All Cancer Indications 2144

Fig 22

2200

amarex

Reimbursement Services

- nsured patients
- Uninsured patients
- claims assistance

Click here for help with a specific plan

plan specific information

Find your patient's health carrier in the list below

Aetna

And find the state level health plan for this patient

Alaska

And find the type of health plan coverage for this patient

POS

GO